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ABSTRACT

Since the identification of self-handicapping strategies in 1978, considerable attention has been paid to this phenomenon. Self-handicapping is a strategy for discounting ability attributions for probable failure while augmenting ability attributions for possible success. Behavioral self-handicaps are conceptually distinct from self-reported claims of handicaps. Males tend to use behavioral self-handicapping more than females. Type A personalities tend to use self-handicapping more than Type B personalities. Self-handicapping is motivated by both self-esteem protection and impression management, but has limited effectiveness as an impression management strategy. The determination of the degree of severity of self-handicapping tendencies can be assessed by examining the level of severity of threat, pervasiveness of self-handicapping impediments, the reversibility and stability of those impediments, and the costs of the impediments. Possible interventions include limiting the settings in which self-handicapping occurs, reducing the level of threat in remaining self-handicapping situations, and bolstering the client's self-esteem through success feedback. Addressing the self-handicapping elements may potentially prove beneficial in the treatment of these syndromes. (Author/ABL)

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SELF-HANDICAPPING BEHAVIOR: A CRITICAL REVIEW OF EMPIRICAL RESEARCH

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SELF-HANDICAPPING BEHAVIOR: A CRITICAL REVIEW OF EMPIRICAL RESEARCH

A Doctoral Research Paper

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Doctor of Psychology

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by

ROBERT STEVEN CARSRUD

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ABSTRACT

SELF-HANDICAPPING BEHAVIOR: A CRITICAL REVIEW OF EMPIRICAL RESEARCH

Robert Steven Carsrud

Self-handicapping (Jones & Berglas, 1978) is a strategy for discounting ability attributions for probable failure while augmenting ability attributions for possible success. Behavioral self-handicaps are conceptually distinct from self-reported claims of handicaps. Males tend to use behavioral self-handicapping more than females. Type A personalities tend to use self-handicapping more than Type B personalities. Self-handicapping is motivated by both self-esteem protection and impression management, but has limited effectiveness as an impression management strategy. Possible interventions include limiting the settings in which self-handicapping occurs, reducing the level of threat in remaining self-handicapping situations, and bolstering the client's self-esteem through success feedback.

Self-Handicapping: A Critical Review of Empirical Research

The study of the ways in which people go about developing and maintaining a sense of positive self-esteem has become a major area of interest in both social and clinical psychology. It appears that people will go to great lengths and will adopt complex strategies in order to protect their sense of self-esteem. Berglas and Jones (1978; Jones & Berglas, 1978) introduced the concept of self-handicapping to describe one strategy whereby individuals attempt to control the esteem implications of performance feedback. They defined self-handicapping as "any action or choice of performance setting that enhances the opportunity to externalize (or excuse) failure and to internalize (reasonably accept credit for) success" (Berglas & Jones, 1978, p. 406).

The Berglas and Jones (1978) definition of self-handicapping was largely an extension of Kelley's (1971) discounting and augmentation principles. According to the discounting principle, the role of a given cause in producing a given effect is discounted if other plausible causes for the effect are also present. By extension, an actor is likely to discount ability attributions for a failing performance if there are alternative plausible causes for the failure such as a handicap. According to the augmenting principle, if both a plausible facilitative cause and a plausible inhibitory cause are present for a

given effect, the role of the facilitative cause in producing the effect will be judged greater than if the inhibitory cause were not present. By extension, ability attributions for success will be judged greater in the presence of a plausible handicap than in the absence of such a handicap.

An example of such a self-handicapping behavior is the student who stays out all night prior to a major examination and does not receive adequate sleep. If the student does poorly on his or her test, the failure is attributed to lack of sleep, not lack of ability. If the student does well, this success is attributed to superior ability, as doing well is <u>especially</u> difficult in light of the self-induced handicap. Other examples include the person who exaggerates the effects of illness or injury, or the person who uses alcohol or drugs in such a way that any deficits in performance may be attributed to the substance, not to the person. These self-handicapping situations establish a "no lose" situation in terms of protecting the sense of self-esteem. Poor performances may be plausibly attributed to the presence of the handicap rather than to lack of ability. Conversely, ability attributions for successful performances may be augmented due to the presence of the handicap.

In the decade since the publication of the Berglas and Jones articles, considerable attention has been given to self-handicapping phenomena. The existing body of

literature was located through two primary means. Utilizing Social Sciences Citations Index for the years 1978 through 1987 as a primary source, twenty empirical studies examining self-handicapping phenomena were located. Two additional empirical studies of self-handicapping phenomena were located through a computer search of the PsychInfo data base. Also, three studies were located that examined how self-handicapping individuals are socially perceived.

The primary purpose of this paper is to critically review the body of empirical research on self-handicapping in order to provide better understanding of self-handicapping behavior, of the characteristics common to self-handicappers, and of the situations in which people are most likely to self-handicap. Clinical implications of self-handicapping will also be discussed.

Initial Demonstration of Self-handicapping

Berglas and Jones (1978) hypothesized that the individuals most likely to self-handicap would be those with a history of noncontingent reward as opposed to either contingent reward or no reward. At one extreme, they described those who know that they have the talent or ability to master life's challenges. Such individuals are likely to have had histories in which they have obtained rewards contingent on the diligent application of their abilities and would be unlikely to utilize a defensive

strategy such as self-handicapping. On the other extreme, Berglas and Jones described individuals who rarely enjoy success at anything, have had few rewards, and who have subsequently been forced to lower their expectations about themselves and their ability to impact their environment.

> We now propose that self-handicappers fall between these two extremes and that their strategic orientation stems from a capricious, chaotic reinforcement history. It is not that their histories are pocked with repeated failure; they have been amply rewarded, but in ways and on occasions that leave them deeply uncertain about what the reward was for. (p. 407)

Individuals with such a chaotic reinforcement history would have a combination of a strong desire to succeed and a high level of uncertainty regarding their ability to succeed. In particularly threatening potential failure situations, a self-handicapping strategy might protect the individual from a loss of self-esteem by providing an alternative plausible explanation for anticipated failure, thus allowing him or her to discount the likelihood of a low-ability attribution. The person is able to maintain the illusion that all that would be necessary to succeed in the future would be to eliminate the easily controllable handicap. This illusion would be further strengthened by those relatively rare instances in which the person experienced success despite the presence of the handicap, thus augmenting the attribution to superior ability.

In further developing their description of the proposed etiology of self-handicapping, Berglas and Jones (1978) stated:

> To the extent that individuals have passed through a history of noncontingent reward, they may have a strong sense of being impostors or pretenders. They do not deserve their rewards because they did not really do anything to earn them. They were just lucky, they happened to be in the right place at the right time, the evaluation standards were lax--any of these subjective hypotheses are consistent with the underlying fear that (a) successful performance cannot be repeated or sustained and (b) impostors must eventually pay for their inequitable current receipts. (p. 407)

In the first experiment of the Berglas and Jones (1978) study, 96 college students were given the opportunity to self-handicap or not to self-handicap as evidenced by their choice of a bogus drug. The subjects were tested on either soluble or insoluble analogies and progressions problems and were provided with success feedback. The feedback was contingent on actual performance for half of the subjects, while the success feedback was noncontingent for the other half of the subjects.

A second factor was included as a test to determine whether self-handicapping would occur only in a "public" setting as a means of impression management or also under conditions of "privacy." For half of the subjects in each contingency condition the assistant who had administered the pretest informed the experimenter in the subject's presence that the subject had attained one of the highest scores on the test. The other half of the subjects received success feedback from the assistant, but were admonished not to reveal their scores to the experimenter in order that he might remain "blind" and so maintain

experimental control.

Following the pretest, success feedback and privacy manipulation, all subjects were given the opportunity to select either a drug alleged to facilitate performance, a drug alleged to inhibit performance, or no drug (as a "control"). They were informed that they would be re-tested following the ingestion of the drug. Self-handicapping was operationalized as the tendency to select the performance inhibiting drug, thereby providing the opportunity to attribute anticipated failure on the re-test to the drug rather than to lack of ability. It was predicted that those subjects who received feedback that they had done well on the insoluble problems (noncontingent success) would be most likely to self-handicap in this manner.

The results showed the anticipated result with the subjects in the noncontingent condition showing a significantly greater tendency to choose the inhibiting drug than the enhancing drug. The significant contingency by sex interaction showed that the effect was attributable largely to the choices made by the male subjects. There was no significant effect of publicity condition on the main dependent variable of drug choice.

A second experiment (Berglas & Jones, 1978) was planned to examine the role of success feedback, to rule out the possibility that the difference between the selections of the contingent and noncontingent groups was

due to differential levels of reported success on the first test, and to see if the sex differences observed in the first experiment would be replicated. The prediction was that subjects would prefer the performance-inhibiting drug only in the condition in which the problems were insoluble and they had received success feedback. This prediction was confirmed, and was again only true for the male subjects.

Additional Demonstrations of Self-Handicapping

In subsequent research self-handicapping has been operationalized in a variety of ways. Some research has shown that subjects threatened by the prospect of failure sometimes choose to take performance-reducing drugs, including alcohol, prior to performing (Gibbons & Gaeddert, 1984; Kolditz & Arkin, 1982; Tucker, Vuchinich, & Sobell, 1981). Other research has suggested that people spend less effort on tasks where success is uncertain, thus providing the possibility of attributing potential failure to lack of effort rather than lack of ability (Frankel & Snyder, 1978; Pyszczynski & Greenberg, 1983; Rhodewalt, Saltzman, & Wittmer, 1984; Snyder, Smoller, Strenta, & Frankel, 1981). Still other research has shown that self-reports of excessively high levels of anxiety or recent or current health problems can be used in a self-handicapping way as an attribution to an agency outside of the individual's control if such handicaps can be reasonably linked to

performance deficits (Smith, Snyder, & Handelsman, 1982; Smith, Snyder, & Perkins, 1983; Snyder, Smith, Augelli, & Ingram, 1985). Rhodewalt and Davison (1986) demonstrated that when threatened by the prospect of failure, people are more likely to select a less-than-optimal environment, such as a room with distracting music, for further performance.

In discussing the various ways in which self-handicapping has been operationalized, Leary and Shepperd (1986) suggested that an important distinction needs to be made between two types of self-handicapping. They stated:

> We would like to suggest that the term behavioral self-handicapping be used to refer to the actions of people who construct handicaps that augment non-ability attributions for possible failure. . . . The use of verbal claims that one possesses handicaps that interfere with one's performance might be labeled self-reported handicaps. (p. 1267)

The authors indicated that the distinction is between the acquisition of a self-handicap and the claim of having a self-handicap, whether or not the claim is true. Thus, for example, a claim of a history of significant past traumatic experiences (as in Degree & Snyder, 1985) does not require any current behavioral choice and may not be seen by the subject as an impediment to current successful performance.

The distinction between behavioral self-handicaps and self-reported handicaps may not always be as clear-cut as Leary and Shepperd (1986) suggested. The use of drugs or alcohol is reasonably assumed to impair performance, and,

in self-handicapping theory, may be unconsciously chosen in order to take advantage of the self-esteem protecting aspects of that impairment. This qualifies as an acquired impairment by the authors' criteria.

In comparison, the impairment suffered by an individual who has unconsciously generated an anxiety attack or an asthma attack may be seen simply as a claim to a handicap, but may also be seen as the acquisition of an impairment. Admittedly, in the former example the impairment is acquired through the use of an external agent, while this is not true in the latter case. However, even this distinction is unclear in the illustration of a person with a simple phobia who uses the presence of an outside agent, the phobic object, to initiate self-handicapping impairment.

The current research does not adequately clarify whether or not behavioral self-handicapping represents a process that differs significantly from self-reported handicaps. One highly salient difference between the studies of behavioral self-handicapping and self-reported handicapping is the accessibility of the handicap to objective scrutiny. The subject who selects a performance inhibiting drug is making a choice that can be objectively measured and that can be reasonably assumed by both the subject and the observer to result in an actual reduction in performance level. The subject who claims a handicap such as test anxiety may actually be experiencing this

symptom or may be merely making the claim in an attempt at impression management. In keeping with the original concept as developed by Berglas and Jones (1978), a true self-handicap must be seen as an impediment to successful performance. Self-reported handicaps may or may not be perceived by the subject as an actual impediment to performance. If these symptoms are <u>not</u> perceived by the subject as an impediment to performance then it may be concluded that this type of self-handicapping is predominately an attempt at impression management rather than self-esteem protection. There is no way to objectively determine at this time how strongly the subject believes in the impact of his or her symptom.

The preceeding paragraphs have provided an overview of the various ways in which self-handicapping phenomena have been demonstrated to date. In order to more fully understand the underlying motivations for this type of behavior, and to link empirical demonstrations to theoretical formulations, it will be necessary to examine in more detail the types of settings in which self-handicapping has been demonstrated as well as the characteristics of those individuals who choose this type of behavior. In other words, who are the people who self-handicap, under what circumstances, and why?

Characteristics Of Self-Handicappers

Gender Differences

Berglas and Jones (1978) reported that male subjects demonstrated a self-handicapping pattern of drug selection prior to a promised retest of ability following noncontingent success while female subjects did not demonstrate this pattern. In subsequent research using only male subjects self-handicapping has been demonstrated through performance-inhibiting drug selection (Kolditz & Arkin, 1982; Weidner, 1980), self-reports of test anxiety (Greenberg, Pyszczynski, & Paisley, 1985), practice effort withdrawal (Rhodewalt, Saltzman & Wittmer, 1984), and alcohol consumption (Tucker, Vuchinich, & Sobell, 1981).

Studies using only female subjects have demonstrated claimed self-handicaps of test anxiety (Smith et al., 1982), physical symptoms (Smith et al., 1983), intended withholding of effort (Harris, Snyder, Higgins, & Schrag, 1986; Pyszczynski & Greenberg, 1983), poor mood (Baumgardner, Lake, & Arkin, 1985), and traumatic life events (Degree & Snyder, 1985) when such claims could serve as plausible excuses for poor performance. Bordini, Tucker, Vuchinich, and Rudd (1986) were unable to demonstrate alcohol consumption as a self-handicapping strategy among female subjects in a procedure that followed Berglas and Jones (1978) and Tucker et al. (1981).

Few self-handicapping studies have been conducted with both male and female subjects. Frankel and Snyder (1978)

and Snyder et al. (1981) used both male and female subjects, but did not include gender differences in their report of results, their statistical analyses, or their discussion. The studies that have compared male and female subjects will be examined in more detail.

Harris and Snyder (1986) administered a self-report measure of self-esteem to a group of 169 college students. They also asked the students how certain they were of their responses to each of the self-esteem items. From these responses, they selected 54 male and 54 female subjects based on their extreme scores for both self-esteem and certainty. The result was a 2 X 2 X 2 (gender by level of self-esteem by certainty of self-esteem) design. The subjects were told that they were to be given "a widely used intelligence test." They were instructed in the advantages of practicing prior to the test and then were given as much time as they desired to practice prior to taking the test. Self-handicapping was operationalized as not taking advantage of the opportunity to practice prior to the testing session. It was predicted that low self-esteem subjects would be more likely to self-handicap than high self-esteem subjects, and that subjects who were uncertain of their self-esteem would be more likely to self-handicap than subjects who were certain of their self-esteem. These predictions emphasize both the hypothesized self-esteem-protecting function of self-handicapping and the idea that it is those individuals

who are uncertain of their ability to perform well in a future evaluative situation that will be the most likely to utilize this type of defensive strategy.

The results showed a main effect in which males worked a fewer number of practice problems than females. In addition, there was a sex X certainty interaction in which males who were uncertain of their self-esteem worked fewer practice problems than either uncertain females or certain males. Uncertain males also spent significantly less time practicing than uncertain females.

The authors also assessed the subjects' level of state anxiety at the beginning of the experiment, immediately prior to the practice period, and after the practice period. All groups of subjects demonstrated some increase in anxiety during the practice period. High self-esteem subjects reported less state anxiety overall than low self-esteem subjects. The change in anxiety was positively correlated with the amount of time spent practicing only for the uncertain males, not for any other group. The authors interpreted these results as indicating that the uncertain males were able to reduce their anxiety about an esteem-threatening evaluative situation by using withheld practice as a self-handicapping strategy. It may be noted, however, that the uncertain males did not, in fact, reduce their anxiety. Anxiety increased for this group as well as for all of the other groups. The distinction of the group of uncertain males was that the more they practiced the

more anxious they became, while practice was not related to increase in anxiety for the other groups. Thus the uncertain males appear to have limited the increase in their anxiety levels by withholding practice.

These results may be interpreted in two ways. It is possible that the withholding of effort by the uncertain males did indeed represent self-handicapping behavior, as suggested by the authors. In this case the increase in anxiety with practice would be explained by the gradual removal of the plausible alternative explanation of lack of practice for potential failure. Alternatively, it may be that this group was more sensitive than the other groups to the anxiety aroused by the future evaluative situation. Work on the practice problems may have focused the subjects' attention on the evaluative task, thus increasing the level of anxiety. In this case, the withholding of effort might be seen as an attempt to avoid the anxiety associated with the evaluative situation. The difficulty in attempting to support either of these alternative hypotheses arises in part from the manner in which self-handicapping was operationalized in this study. By defining self-handicapping as the absence rather than presence of a particular behavior, it is difficult to determine if the absence of that behavior in fact represents an active attempt at esteem protection or an avoidance of that behavior for some other reason.

Whether the lower practice levels of the uncertain

males were due to a self-handicapping strategy or an attempt to avoid thinking about the test, there remains the fact that the uncertain females did not respond in a similar manner. It may be that females are not as threatened by a test of intelligence as are males. Those studies that have demonstrated self-reported handicaps among females have used a test of "social intelligence" as the evaluative situation. It may be that females are more threatened by the prospect of performing poorly on a test of social alacrity than on a test of academic intelligence. However, the hypothesis that the female subjects in the Harris and Snyder (1986) study did not experience a threat to their self-esteem is contradicted by the lack of a significant main effect for gender on level of state anxiety. The females were as anxious as the males.

It may also be that lack of practice effort did not represent a plausibile explanation for possible poor performance for the female subjects. In order to fit with the theoretical explanation of self-handicapping, a handicap must both provide a plausible alternative explanation for poor performance and must be seen as more socially acceptable than the characteristic being threatened. Self-esteem cannot be protected by selecting a self-handicap that emphasizes a highly socially undesirable trait. The student who is unsure of his or her intellectual ability may adopt a self-handicap that allows for an explanation of laziness for poor performance, but is

unlikely to adopt a self-handicap that allows for an explanation of mental illness. Lack of practice may have been seen by the female subjects in the Harris and Snyder (1986) study as being unlikely to result in reduced performance. This seems unlikely in light of the explicit statements by the experimenter regarding the benefits of practice. Alternatively, lack of practice may have been seen as "laziness" by the female subjects, who may have perceived such an attribution as being more highly negative than a low ability attribution.

The two areas discussed above, different levels of threat to the self-esteem in similar situations and different perceptions of the acceptability of the self-handicapping option, have been discussed by some of the researchers in an attempt to understand the observed sex differences in self-handicapping behavior. In discussing the absence of a clear self-handicapping trend among their female subjects, Berglas and Jones (1978) noted that the female subjects demonstrated a non-significant trend toward attributing their initial success to luck rather than to ability. They stated, "Females may have seen less reason to protect a success readily acknowledged to be based on luck" (p. 416). In a similar vein, Bordini et al. (1986) speculated that their failure to find self-handicapping among their subjects might have been due to the task not engaging the self-esteem of the subjects. Alternatively, it may be that women prefer

self-handicapping behaviors other than the use of drugs or alcohol. In this regard they cited evidence that alcohol abuse carries a greater social stigma for women than for men. Thus two major possible explanations for the relative lack of demonstrated behavioral self-handicapping among females involve the selection by researchers of tasks that do not sufficiently engage the self-esteem of females or that do not provide socially acceptable means of self-handicapping for females.

One other possible explanation for the observed gender differences in both the Berglas and Jones (1978) and Harris and Snyder (1986) studies bears exploration. It may be that females do not expect to be able to exert as much control over their environments as males. That is, males may believe that they can (or should be able to) control their performance on a test such as an intelligence test to a greater degree than females. In essence, such an explanation would be an indication that males tend to expect to succeed and to be able to make internal attributions for that success. When faced with failure, males may experience a stronger threat to the self-esteem than females and may go to greater lengths in order to arrive at plausible external attributions for that failure. The stronger self-handicapping effects observed by Berglas and Jones and by Harris and Snyder may then be a demonstration of a need by males to obtain stronger alternative external attributions for poor performances

than their female counterparts in order to attain the same level of esteem protection. This interpretation would be consistent with Berglas and Jones' observation that their female subjects attributed their initial success more to luck than their male counterparts. The authors indicated that "numerous other studies" have also demonstrated a similar tendency for female subjects to attribute their success to luck following success feedback (Berglas & Jones, 1978, p. 416).

Additional support for the hypothesis of differential expectations of control between males and females is found in a study by Rhodewalt and Davison (1986). They randomly assigned equal numbers of male and female subjects to one of four performance feedback conditions. All subjects were told that they would be taking two forms of a nationally used test of intelligence, the first without music and the second with music. Subjects in the success feedback condition were told that the average student answered only 5 out of 20 items correctly on the test. Failure feedback subjects were told that the average student correctly answered 15 out of 20 questions. All participants were led to believe that their actual score on the first test was 10 out of 20. Thus the success feedback subjects were told that they had done significantly better than average, while the failure feedback subjects were told that they had done significantly worse than average.

Subjects in the contingent feedback condition were

given problems of differing levels of difficulty in such a way as to insure that each subject correctly answered 10 out of the 20 problems while still providing the subject with accurate (contingent) feedback regarding success or failure on each item. Noncontingent feedback subjects were given an assortment of moderately difficult, difficult, and insoluble problems and a random (noncontingent) pattern of performance feedback indicating that they had solved 10 problems. Thus the overall design was a 2 X 2 X 2 (sex X success-failure X contingency) design.

Following the first test, subjects were allowed to select the music they were to listen to during the second test. They chose one of seven reels of audiotape labeled from facilitating (1) to extremely distracting (7) with the fourth tape essentially neutral. In fact, all reels of tape contained the same music. Self-handicapping was operationalized as the tendency to select distracting music, thus providing a plausible alternative to low ability for possible poor performance on the second test.

In a pattern of results similar to those reported by Berglas and Jones (1978) and Harris and Snyder (1986), only male subjects who had received noncontingent success feedback showed a clear preference for the debilitating music. Two additional findings bear directly on the gender difference issue. In addition to the choice of music, the authors had each subject complete a questionnaire designed to assess his or her perceptions of the experiment.

Included were items that asked them to rate their performance on the first test, how much control they believed they had over the test outcomes, and how much effort they expended on the second test compared to the first.

Male subjects viewed their performance significantly more positively than female subjects regardless of the feedback. Also, males viewed their outcomes as significantly less controllable if the feedback was noncontingent than if it was contingent while females did not demonstrate this difference. These findings are consistent with the hypothesis that males tend to expect to have greater control over their environments than females, and may indicate a greater sensitivity to circumstances that do not yield readily to the expected control.

In summary, while it appears that there are significant gender differences in the tendency to use self-handicapping strategies, the reasons for those differences are not clear. One possible explanation focuses on the limitations of the studies completed to date and the limited number of studies directly comparing the self-handicapping behavior of males and females. It may be that the stronger self-handicapping demonstrated by male subjects as compared to female subjects was due to the choice of a task that did not sufficiently engage the self-esteem of the female subjects, the choice of a method of self-handicapping that was unattractive to the female

subjects, or both. In comparing the self-handicapping behavior of males and females it is noteworthy that at the present time no research has clearly shown behavioral self-handicapping among female subjects.

Another possible explanation is that males may have a stronger belief than females that they should be able to have control over their environment and they may detect noncontingently rewarding situations more effectively. Thus uncertainty regarding future performance may motivate males to take stronger measures to provide a plausible alternative to a low ability explanation for poor performance. This possibility appears to have some support.

In addition to gender differences, personality differences appear to have some impact on the tendency to self-handicap. One cluster of personality variables has been clearly identified that appears to correlate positively with the tendency to self-handicap.

Type A Coronary Prone Behavior Pattern

Weidner (1980) utilized a procedure similar to that used by Berglas and Jones (1978), though with two major departures. First, she used the median score on the student version of the Jenkins Activity Survey (JAS; Glass, 1977) to divide her subjects into a Type A coronary prone behavior group and a Type B group. The Type A behavior pattern includes competitive achievement strivings, time urgency and aggression. According to the researcher, Type

researcher, Type A's are at least twice as likely as Type B's to develop heart disease. She also provided her subjects in the noncontingent feedback condition with failure feedback rather than success feedback. Thus the experiment comprised a 2 X 2 (gender by success/contingency feedback) design. She found that Type A's in the noncontingent failure condition were less likely to choose the allegedly performance-enhancing drug than either Type A's in the contingent success condition or Type B's in either condition. Type A's in the noncontingent failure condition also reported marginally less effort than Type A's in the contingent success condition whereas Type B's did not differ between conditions on this measure.

Harris, Snyder, Higgins, and Schrag (1986) also included a comparison of Type A subjects with Type B subjects and did not find any significant differences between these groups. The fact that these researchers used only female subjects while Weidner (1980) used only male subjects suggests the possibility of a gender X level of coronary prone behavior interaction in the use of self-handicapping strategies. It is also possible that the proposed difference between males and females regarding expectations of control over the environment mentioned earlier is relevant to the comparison of Type A and Type B subjects. Weidner (1980) stated:

> When confronted with salient uncontrollable events, Type A's increase their initial efforts to assert control. However, extended exposure to uncontrollability leads to greater helplessness in

> Type A's than in Type B's. . . . Since Type A's show more pronounced signs of learned helplessness than Type B's when faced with salient uncontrollable events, it is suggested that Type A's and B's may differ in terms of attributions made for this perceived noncontingency, i.e., Type A's may make more internal attributions for failure than Type B's and also experience loss of self-esteem. (pp. 319-320)

It appears that Type A's demonstrated a greater expectancy of ability to control their environments than Type B's in the same way that males may demonstrate this tendency to a greater degree than females. One way of characterizing the Type A individual is as a person who always expects to succeed at everything. As a result, Type A's, and particularly male Type A's, would be particularly prone to esteem-protecting strategies such as self-handicapping. It is even possible that the Type A behavior pattern is to some degree an extended self-handicapping strategy. By constantly taking on too many projects at the same time, failure in any one area may be attributed to the excessive burden the person is carrying rather than to lack of ability.

As alternative explanations for the discrepancy in their two studies, Harris et al. (1986) noted that Weidner (1980) had confounded non-contingency with failure and that the mean value for the drug selections of the Type A subjects in the noncontingent failure condition was essentially a choice of no drug rather than a clear choice of an inhibiting drug. They stated, "The relatively passive behavior of Type As following failure runs counter to the theoretical premise that self-handicapping involves

active attempts to adopt a performance impediment in anticipation of failure" (p. 1191). This is another example of a study in which failure to demonstrate a particular behavior, in this instance the choice of the facilitative drug, is defined as self-handicapping but may actually be the result of some form of avoidance behavior.

It appears then that although Type A's in general may be more confident of their ability to control their environment, they are also more sensitive to situations where this control breaks down and perhaps would be more motivated to attempt to make external attributions in failure situations. In this vein, research by Houston and Kelley (1985) suggests that Type A persons feel less sure of themselves and tend to report higher fear of failure than do Type B persons. This finding confirms the statement that "Type A is an outgrowth of poor self-esteem" (Price, 1982, p. 109).

Psychological Symptoms

In a series of studies, C. R. Snyder and his colleagues, among others, have discussed the use of psychological symptoms in a self-handicapping manner. Smith, Snyder, and Perkins (1983) studied the manner in which hypochondriacal complaints could be used in a self-handicapping manner. The researchers preselected 120 subjects with the highest and lowest scores from a distribution of 514 females' scores on the MMPI Hs scale. Subjects were randomly assigned to one of two evaluative

conditions or to a nonevaluative condition. Subjects in the evaluative conditions were told that the study was being conducted to develop local norms for a widely used test of "social intelligence," and that they would receive feedback on how well they had performed. Subjects in the nonevaluative condition were told that the task was not highly evaluative, that their scores were unimportant, and that the main emphasis was to get their feedback regarding the task. The subjects in the evaluative-no-effect condition were told that past and present physical symptoms had no effect on the results of the social intelligence test. Subjects in the evaluative-no-infomation condition received no such information.

The results indicated that the high-hypochondriasis subjects in the evaluative-no-information condition reported more past and present physical complaints than high hypochondriasis subjects in either the evaluative-no-effect condition or the nonevaluative condition. Low hypochondriasis subjects demonstrated no such pattern.

The authors concluded that the high hypochondriasis subjects in the evaluative-no-information condition had utilized reporting of physical symptoms in a self-handicapping manner. By establishing poor health as an alternative explanation for poor performance, they were able to discount a low ability attribution for poor performance. The high hypochondriasis subjects who were

told that physical symptoms had no effect were unable to appeal to physical symptoms as an alternative explanation. The low hypochondriasis subjects were assumed not to have utilized a report of physical symptoms in a self-handicapping manner because "nonhypochondriacal individuals do not commonly use reports of physical illness and physical symptoms as self-handicaps" (Smith et al., 1983, p. 789). This circular reasoning reflects a weakness in the discussion of the results of the study. A more direct statement is the possibility that the nonhypochondriacal subjects did not find the report of physical symptoms to be a socially acceptable alternative explanation to low ability for poor performance. For high hypochondriasis subjects it may be better to be seen as sick than as lacking in social intelligence. For low hypochondriasis subjects to be seen as sick may have more negative implications.

Other researchers have used a similar procedure in which subjects have been preselected according to their extreme scores on a measure of a psychological symptom, placed in an evaluative situation and given either no information about the effect of the symptom on performance or told that the symptom has no effect on performance. A similar pattern of results was found with subjects high in the symptom reporting more of that symptom unless they were informed that the symptom would have no effect on performance. Symptoms studied in this manner have included

test anxiety (Greenberg et al., 1985; Smith et al., 1982), poor mood (Baumgardner, Lake, & Arkin, 1985), history of traumatic events (Degree & Snyder, 1985), and social anxiety (Snyder et al., 1985).

In each of these studies the form of self-handicapping demonstrated is a self-reported handicap. All of the studies except one included a condition in which subjects were instructed that a particular characteristic or symptom did not interfere with performance on the task being presented. The single exception (Baumgardner et al., 1985) compared subjects who were given no instructions with subjects who were told that the characteristic being studied (poor mood) would have a negative effect on performance. They found that the subjects who were told that negative mood would have a negative impact on performance reported a higher level of negative mood in the condition where they believed that the experimenter had access to their results, but not in the relatively "private" condition where they believed that the experimenter did not have access to their results.

The only study to include both a condition in which the subjects were told that the characteristic being studied (test anxiety) would have a negative impact on performance and a condition in which the subjects were told that the characteristic would not impact performance was the study by Smith et al. (1982). The group given no information regarding the effect of test anxiety on

performance was called the "implicit self-handicapping" group. The group instructed that test anxiety would have a negative impact on performance was called the "explicit self-handicapping" group. Finally, the group instructed that test anxiety would have no impact on performance was called the "no self-handicapping" group.

The researchers predicted and found that subjects who had been selected on the basis of high trait test anxiety reported higher levels of state test anxiety in the implicit self-handicapping condition than in the no self-handicapping condition. In addition, they predicted but did not find that high trait test anxious subjects in the explicit self-handicapping condition would also report higher levels of state test anxiety than their counterparts in the no self-handicapping condition.

This failure to find a significantly higher level of reported state test anxiety among the explicit self-handicapping subjects points to a possible weakness in the experimental design of this group of studies. There may have been some demand characteristic of the experimental design that led to the relatively lower reports of the characteristic being studied for the groups of subjects who were told that the characteristic would not impact performance. Simply having their attention drawn to the topic of test anxiety may have caused highly test anxious subjects to either reduce their actual level of test anxiety or to reduce their level of reported test

anxiety. It would not be hard to imagine students who had experienced difficulties with test anxiety in the past learning relaxation techniques for dealing with that anxiety, but not using those techniques until reminded to do so by some outside influence. The experimental situation could very well serve as a reminder to such subjects.

In the Smith et al. (1982) study the same demand characteristics would exist for both the explicit self-handicapping condition and the no self-handicapping condition in which the subjects were told that test anxiety would not impact their performance. This similarity in demand characteristics would explain the failure to find the expected relatively higher levels of self-reported state test anxiety among the explicit self-handicapping group. Until additional research is done utilizing a design similar to that of Smith et al. (1982) to examine claims of other psychological characteristics and symptoms in these situations it cannot be conclusively determined whether these claims represent true self-handicapping (alternative explanations for possible poor performance) or some other response to the experimental situation.

In an indirectly related series of studies, Snyder, Ingram, Handelsman, and Wells (1982) focused on one of the underlying assumptions of self-handicapping, the idea that some individuals do not desire accurate feedback about themselves because of the fear that any such information

would confirm their lack of ability. Subjects from different samples were surveyed to determine the degree to which these subjects did or did not desire feedback about themselves. A substantially lower proportion of psychiatric patients, as compared to non-patients, reported a high desire for feedback. Additionally, patients voluntarily participating in an inpatient alcohol treatment program reported a higher desire for feedback than patients who were participating involuntarily. There was a non-significant trend for subjects with a high desire for feedback to have sought psychological help in the past. Finally, among clients first coming for outpatient treatment, desire for feedback correlated positively with expectations about personal participation and therapist's effectiveness in treatment.

While this research does not directly demonstrate self-handicapping, the attributional ambiguity apparent in low-feedback situations is consistent with the underlying assumptions involved in self-handicapping. The possibility that clinical populations are more likely to self-handicap than non-clinical populations is an important issue. The tendency for patients in mental hospitals to purposefully vary presentation of their symptoms in order to achieve tangible benefits has been empirically demonstrated (Braginsky & Braginsky, 1967; Braginsky, Braginsky, & Ring, 1969; Braginsky, Grosse, & Ring, 1966; Braginsky, Holzberg, Ridley, & Braginsky, 1968). Is it possible that such

patients may also alter their symptoms in order to protect a sense of self-esteem by avoiding inability attributions for failure experiences? Additional research is needed that will directly address this issue.

In the preceeding sections individual characteristics have been examined that appear to relate to the use of self-handicapping behavior as a defensive strategy. Evidence has been given to suggest that males are more likely to self-handicap than females, persons demonstrating the Type A coronary prone behavior pattern are more likely to self-handicap than Type B persons, and persons demonstrating any of several different psychological symptoms use reports of those symptoms in a self-handicapping manner. It is important to recognize that self-handicapping does not occur in a vacuum. In addition to having a tendency to utilize this type of strategic defense, the individual must be in a situation where self-handicapping would serve to protect threatened esteem. An understanding of the characteristics of such situations is essential to a complete understanding of the self-handicapping phenomenon.

Self-Handicapping Situations

Public versus Private

The main focus of research on self-handicapping, and particularly on behavioral self-handicapping, has focused on the assumption that such strategies serve as a means of

protecting a tenuous sense of self-esteem. An alternative explanation of self-handicapping phenomena is based on impression management theory. According to this explanation, the self-handicapper is not attempting to protect a tenuous sense of self-esteem but rather to control the attributions made about him or her by others. The direction of the attempted control of attributions is the same, to maximize external attributions for failure and internal attributions for success. The difference is whether the proposed alternatives to ability attributions are plausible to the self-handicapper, to significant others, or to both.

Berglas and Jones (1978) found that their male subjects demonstrated a self-handicapping drug choice even "under conditions of total privacy" (p. 407). The female subjects demonstrated a non-significant trend toward self-handicapping drug choice only in the first experiment in which their performance was known to the experimenter. In contrast, Kolditz and Arkin (1982) gave their male college student subjects a task in which they were given either contingent or noncontingent success feedback. They were then told that they would be retested while under the influence of either an allegedly performance-enhancing drug or an allegedly performance-inhibiting drug and were allowed to choose a preferred drug and drug dosage. Allegedly the retest was to take place either with or without the experimenter's knowledge of the results, and

the choice of drug was made either with or without the experimenter's knowledge of the choice made. The subjects in the noncontingent success group demonstrated a self-handicapping tendency to select the inhibiting drug, but this effect was apparent only when the experimenter was aware of the drug choice. This result suggests that self-handicapping may be more of an attempt to control others' attributions regarding one's abilities than an attempt to control one's own attributions about those abilities. Adjusting one's self reports according to potential attributions made by a researcher in experimental studies can be considered a response to the demand characteristics of the experiment. Once again the observed self-handicapping behavior can be seen as a form of response to demand characteristics.

Greenberg et al. (1985) utilized a procedure similar to the one outlined earlier used by C. R. Snyder and his colleagues. Subjects were divided into low and high trait test-anxious groups and half of the subjects from each group were randomly assigned to a condition in which they were given no instructions regarding the impact of test anxiety on performance. The other half of the subjects were assigned to a condition in which they were informed that test anxiety would have no impact on performance. In addition, the authors carefully instructed their subjects not to use their own names, but rather to identify all of their materials by the use of a randomly selected code

number. The experimenters were able to demonstrate self-handicapping claims of test anxiety even under these conditions of "privacy." Interestingly this effect was only found among subjects who were told that the "prize" for successful performance was $5, and not among the subjects who were told that the "prize" was $25. The authors stated:

> Thus it appears that extrinsic incentives can sometimes disrupt the use of defensive strategies for protecting self-esteem. When the incentive for success was substantial, high levels of test anxiety were not perceived by no-information subjects because they presumably believed that such anxiety would interfere with acquisition of the valuable prize (p. 1142).

The conflicting results of the studies surveyed make it unclear whether self-handicapping is the result of an attempt to limit diagnostic information about one's own ability or an attempt at impression management, or both. The results currently available suggest that both processes may be involved in the use of self-handicapping as a defensive strategy. Aside from situations in which self-handicapping is used to protect against a loss of esteem, there may be situations also in which self-handicapping is used to bolster a flagging sense of self-esteem. Such a situation would represent an acquisitive use of a self-handicapping strategy.

Protective versus Acquisitive Strategies

Self-handicappers have been characterized as "willing to accept (probable) failure if it can be explained away and if (possible) success will have augmented value for

self-esteem" (Berglas & Jones, 1978, p. 406, emphasis in original). Arkin and Baumgardner (1985) have pointed out that "these two factors have not been unconfounded and it is not yet clear that both motives are necessary to the self-handicapping phenomenon" (p. 501). The bulk of the research to date has focused on self-esteem threatening situations in which self-handicapping strategies seem to serve primarily to ensure that an alternative explanation for potential failure is available. This is primarily a protective strategy by which the individual hopes to retain what measure of self-esteem is already in place. In contrast, an acquisitive strategy would focus on the possible increase in self-esteem to be gained in the case of success despite the presence of the handicap. Possible failure would still be attributed to external factors in an acquisitive strategy. In essence, protective strategies are to be expected in situations where failure is anticipated (though uncertain), while acquisitive strategies are to be expected in situations where success is anticipated (though uncertain).

While the two factors have not been completely unconfounded, the research completed to date has tended to demonstrate self-handicapping in those situations where self-esteem is likely to be threatened and success is uncertain. In addition, those individuals who are most uncertain of their self-esteem appear to be the most likely to utilize self-handicapping strategies (Harris & Snyder,

1986).

Perhaps part of the reason for the unidirectionality of the research findings to date is based on a tendency to see protective strategies as signifying greater problems and acquisitive strategies as being more "normal." Acquisitive self-handicapping can be observed in a variety of normal social situations. For example, an adolescent boy may challenge a younger brother to a race, stating, "I'll give you a head start!" The older boy may be attempting to bolster his self-esteem by demonstrating that he can beat his brother despite the handicap.

A classic example of this kind of acquisitive self-handicapping occurred in the early 1970's when Bobby Riggs challenged Billie-Jean King to a tennis match. Mr. Riggs was in a no-lose situation. If he lost the match, he could attribute his failure to his age. If he won, he could augment his attribution to ability because of his age. While age is not a controllable self-handicap, Mr. Riggs went on to enjoy a period of notoriety utilizing more controllable handicaps. He challenged various celebrities to tennis and table-tennis matches while handicapped by extraneous clothing such as boots, inappropriate equipment, or even by placing chairs on his side of the court as obstacles ("Still Hustling," 1974). The example of Bobby Riggs illustrates what seems to be a fairly common behavior. Unfortunately no researcher has yet chosen to operationalize this kind of acquisitive

self-handicapping behavior.

The Importance of Uncertainty

As indicated earlier, the bulk of the research completed thus far on self-handicapping strategies has focused on persons and situations in which future success is uncertain. Self-handicapping strategies serve to increase uncertainty of cause in the case of failure (by discounting the low ability attribution) while increasing the certainty of cause in the case of success (by augmenting the ability attribution). When faced with a potential failure on a self-esteem threatening task, the potential self-handicapper has three basic choices. First, he or she may attempt to increase the possibility of success, thereby reducing the threat to self-esteem. Second, he or she may attempt to increase the uncertainty of the meaning of a failing performance through self-handicapping strategies. Finally, he or she may attempt to increase the probability of failure based on some easily identifiable cause other than low ability. In the first and last of these options, the task is not diagnostic of ability. That is, if success is guaranteed, anyone would be expected to succeed, and the task would provide no additional information regarding ability relative to one's peers. At the other extreme, no one would be expected to succeed at a very difficult task, so again there is no additional information regarding ability relative to one's peers. It is with moderately difficult

tasks that the potential self-handicapper is faced with a situation most diagnostic of ability relative to his or her peers and in which the person is most likely to attempt to limit diagnostic information through the use of a self-handicapping strategy.

Sachs (1982) provided his subjects with success feedback either contingent on performance on soluble problems or noncontingent on performance on insoluble problems. He then allowed his subjects to select items for a second test from four sets of problems with varying levels of difficulty and diagnostic information. He found that contingent subjects chose a greater percentage of high-diagnostic items than did noncontingent subjects, thus supporting a tendency to avoid diagnostic information in an apparently self-esteem threatening situation.

Frankel & Snyder (1978) presented their subjects with either soluble problems with contingent feedback or insoluble problems with noncontingent feedback. They subsequently allowed their subjects to choose the level of difficulty for a fictitious additional task operationalized by the length of time stimulus materials would be displayed on a cathode ray screen. They found that subjects in the insoluble problems condition were more likely than subjects in the soluble problems condition to choose high or low difficulty levels for the fictitious third task. By choosing highly difficult items they could ensure failure based on task difficulty. By choosing very easy items they

could ensure success. This study again provided additional support for the tendency to avoid highly diagnostic information in a potentially self-esteem threatening situation.

It appears then that the self-handicapper actively avoids situations that may be diagnostic of failure. In order to accomplish this, it may be necessary to sacrifice situations diagnostic of success. Thus the self-handicapper isolates himself or herself from the very information that might bolster a sense of self-esteem, in the case of success, and perpetuates uncertainty which leads to an increased likelihood of further self-handicapping in future situations. The self-handicapper is caught in a vicious cycle of desiring to think better of himself, while being unwilling or unable to risk facing the very information that might provide him with that increased sense of self-esteem.

Social Impressions of Self-Handicappers

The self-handicapper sacrifices maximal performance in order to avoid low ability attributions. Very little research has been done at this point to examine the responses of others to such self-handicapping strategies. The research that has been done at this time suggests that society is likely to tolerate such behaviors and to respond in such a way as to reinforce continued self-handicapping.

In a series of surveys, Covington and Omelich (1979a,

1979b, 1981; Covington, Spratt, & Omelich, 1988) examined the personal and interpersonal effects of effort reduction as an alternative to low ability attributions in an educational setting. Subjects were asked to rate how they would evaluate themselves and how they expected others would rate them following failures subsequent to (a) high study effort, (b) high study effort that, by chance, focused on the wrong material, (c) low study effort, and (d) low study effort due to illness. They were also asked to adopt the mind set of "teacher" and to recommend levels of punishment for students whose failures were due to the same causes.

The experimenters found that students taking the role of "teacher" were less likely to punish "students" who had failed a task subsequent to high effort than subsequent to low effort. Nonetheless, ratings of self-evaluations and expected other evaluations were more negative in the high effort conditions. Thus there seems to be a conflict in educational settings with teachers placing greater emphasis on effort and students placing a greater emphasis on ability to the point that they are willing to accept an attribution of low effort, i.e., laziness, in order to avoid an attribution of inability. It should be noted that these findings do not preclude the use of low effort as an impression-management form of self-handicapping as the subjects expected less favorable attributions from others if failure followed high effort. It is the person's

expectations regarding the attributions of others rather than the actual attributions themselves that are the key to understanding how self-handicapping can be attempted as an impression management strategy in situations where the end result is less favorable attributions by others.

Schouten and Handelsman (1987) provided subjects with scenarios in which the protagonist had either experienced a severe reduction in performance at work or had been the perpetrator of spouse battering. Gender of the protagonist was varied, and subjects were given either no information about the protagonist's psychological functioning, a description of current symptoms of depression, or a description of current symptoms of depression plus historical information confirming a pattern of depression including the prescription of anti-depressant medication and psychiatric hospitalization.

Subjects in this study rated protagonists with depressed symptoms (with or without a confirming history of depression) to be less responsible for their problems and less blameworthy than protagonists without such symptoms. In the job scenario, protagonists were also rated as being less the cause of their problems and were expected to assume fewer job responsibilities. Male subjects rated male protagonists to be more responsible than female protagonists, and male protagonists in general were rated as more blameworthy than female protagonists. In the battering scenario female protagonists with depressive

symptoms were more likely to be recommended for treatment, as opposed to prosecution, than female protagonists without symptoms.

It appears from these preliminary findings that there are some instances in which self-handicapping may be effective in reducing personal responsibility for poor performance in the eyes of others. In other instances, however, this does not appear to be the case. The interaction between the self-handicapper's perception of the attributions of others and the actual attributions themselves is an important area for future research.

One possible experimental design would be to place subjects in a situation where self-handicapping has been demonstrated and to collect measures of their performance as well as their attributions about their performance. Subsequently, information regarding the performance and attributions of these subjects could be provided to a second group of subjects who would in turn provide their own attributions regarding the performances of the first subjects. A comparison could be made between the two sets of attributions in order to examine the effectiveness of self-handicapping in actually controlling attributions made by others in comparison to expectations about controlling those attributions. Through use of such an approach it may be possible to determine the extent to which self-handicapping behavior is a learned response to actual social reinforcement and to what extent such strategies

represent a distorted view of the attributional tendencies of others.

Clinical Implications of Self-Handicapping

Normal versus Pathological Self-Handicapping

From the examples discussed previously it appears that self-handicapping is a relatively common occurrence. Simultaneously, it appears that performance deficits due to self-handicapping could cause serious problems in many areas. It is important that a means be found to discriminate "normal" self-handicapping from "pathological" self-handicapping.

Snyder and Smith (1982) have suggested four dimensions along which this distinction may be made. The first of these is the perception of threat. Extreme self-handicappers may experience a higher level of threat in a greater number of situations than low self-handicappers. The athlete who withholds practice effort prior to every competition will be more seriously impaired than the athlete who withholds practice effort only prior to important competitions. In a vicious cycle, the greater the felt threat, the more likely the tendency to self-handicap. The more self-handicapping takes place, the lower the potential for experiences of success. The fewer the experiences of success, the less likely that self-esteem will be bolstered by success. The lower the self-esteem, the greater the felt threat in evaluative

situations.

The second dimension proposed by Snyder and Smith (1982) involves the intensity and pervasiveness of the impediment.

> For example, the softball pitcher's failure to practice the week before an important game has little impact on or relevance to academic, vocational, or interpersonal concerns and is hardly an extreme behavior. In more problematic forms of self-handicapping, however, the impediment has a much wider range of convenience and is much more pronounced. Thus, the chronic alcoholic's drinking is quite likely to interfere with performance in almost all aspects of life and is certainly an extreme form of behavior. (p. 115)

The third dimension discussed is that of reversibility and stability of the impediment. The more the person loses the ability to control the presence or absence of the self-handicapping strategy the more pathological the problem, and the more difficult it will be to overcome. As Snyder and Smith (1982) stated, "it is much easier to become a chronic alcoholic than to stop being one" (p. 115).

The final dimension described is the cost of the impediment. This cost can be assessed in two ways: (a) the value of what is lost directly in admitting to weakness, and (b) the value in what is lost indirectly by the limitations imposed by the handicap. Thus the student who self-handicaps through reduction of effort not only loses that measure of self-esteem related to being a hard-worker, but may also lose out on opportunities to participate in other non-academic activities that require effort, such as

selection for participation on a sports team.

The evaluation of the severity of self-handicapping behaviors along these four dimensions can be useful in assessing the degree to which self-handicapping is an element in a broad range of clinical syndromes. For example, the agoraphobic person may be utilizing his or her symptoms in a self-handicapping manner in order to avoid personal responsibility for potential failure in any of a number of arenas. A thorough understanding of the degree to which the symptoms reflect self-handicapping strategies can assist the therapist in the formulation of an appropriate treatment plan.

Treatment Planning

Once the self-handicapping element in the client's pathology has been identified, several steps can be taken to begin intervening. The client can be aided in identifying specific situations in which he or she experiences threat so that self-handicapping can be limited to those situations. This will reduce the pervasiveness of the impediment, as well as providing the client with a broader range of situations in which to experience potential success and a concomitant increase in self-esteem.

Subsequently, the client can be aided in perceiving more accurately the external influences that may contribute to failure in the threatening situations. It would not be necessary for the client to adopt a self-handicapping

strategy if legitimate external reasons for possible poor performance exist. This step may also allow the client to reduce the frequency and severity of self-handicapping behaviors.

A possible next step involves the reduction of evaluative threat in the other situations that threaten self-esteem. Snyder and Smith (1982) have identified a number of techniques that may be used to reduce threat, including desensitization, implosion, gestalt exercises, the development of cognitive explanations as to why the situation will not be as bad as the client anticipates, and systematic rational restructuring.

Finally, efforts may be made to bolster the client's sense of self-esteem by helping to focus his or her attention on areas in which repeated successes have been experienced and by developing new areas in which success may be experienced. These techniques can all be modified for use with any of a broad range of clinical syndromes with a self-handicapping component.

Conclusions

Since the identification of self-handicapping strategies by Berglas and Jones (1978; Jones & Berglas, 1978), considerable attention has been paid to this phenomenon. Self-handicapping strategies have been identified in a variety of experimental settings which confirm the underlying processes of self-esteem protection

and causal ambiguity for failure. Research has not yet demonstrated a form of self-handicapping motivated by a desire to acquire a higher level of self-esteem. While there is evidence that self-handicapping is largely an attempt at self-esteem protection through control of self-attributions, it may also occur in situations where the primary motivation is to control the attributions of others regarding one's own possible failures.

Self-handicapping has been demonstrated in both male and female subjects, although behavioral self-handicapping has been clearly demonstrated only with male subjects. It is unclear whether this is because (a) the experimental situations used did not engage the self-esteem of the female subjects, (b) the self-handicapping strategy available was unattractive to females, or (c) some other difference between males and females. It was suggested that males may expect to be able to control their environments more strongly than females and may be able to detect noncontingency of control better than do females. Males may therefore be more threatened in situations where control is uncertain.

While some individuals appear to be more likely than others to engage in self-handicapping behaviors, this appears to be a relatively commonplace strategy. The determination of the degree of severity of self-handicapping tendencies can be assessed by examining the level of severity of threat, the pervasiveness of

self-handicapping impediments, the reversibility and stability of those impediments, and the costs of the impediments.

An awareness of the degree of self-handicapping can be useful in evaluation of a broad range of clinical syndromes. Addressing the self-handicapping elements may potentially prove beneficial in the treatment of these syndromes. Possible interventions include techniques for limiting the settings in which self-handicapping occurs, reducing the level of threat in the remaining self-handicapping situations, and bolstering the client's self-esteem through success feedback in other areas.

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